STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 01 B. WING	05/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/17/12 Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Valparaiso Care and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility does not have	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after June 5, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	smoke detectors in resident rooms. The facility has a capacity of 168 and had a census of 144 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/23/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 15 doors serving hazardous areas, such as rooms with fuel fired heaters, automatically close and latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the mechanical room adjoining the Respiratory Office. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, the entry door to the mechanical room containing one natural gas fired water heater, adjoining the Respiratory Office, is equipped with a self closing device, but the door drags on the floor and becomes stuck when opened to any position causing the door to not	K0029	**K 029 NFPA 101 LIFE SAFETY CODE STANDARD** One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard	06/05/2012

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	automatically close and latch into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the mechanical room adjoining the Respiratory Office drags on the floor which causes the entry door to not automatically close and latch into the door frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 15 doors serving hazardous areas, such as storage rooms greater than fifty square feet in size used to store combustible materials, are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the Central Supply storage room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, the access door to the Central Supply storage room is not equipped with a self closing device to latch the door into the door frame. The Central Supply storage room measures		to this regulation. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The mechanical room door has been repaired. An automatic closure has been added to the Central Supply Storage Room. All hazardous areas will have automatic door closures. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Automatic closures are visually checked monthly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	

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	286 square feet and is used to store combustible boxes containing sanitary napkins, gloves and bandages. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Central Supply storage room measures greater than fifty square feet, is used to store combustible supplies and the access door is not equipped with a self closing device. 3.1-19(b)			

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K0064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 1. Based on observation and interview, the facility failed to ensure 11 of 26 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, eleven fire extinguishers had inspection stickers and collars affixed indicating the most recent six year test was completed in either August 2003 or August 2004. The fire extinguisher 's were located by Room 103, by the East Wing MDS Office, by Room 130, in the Cottage Dining Room, by Room 144, by the Cottage Nurse's Station, in the West Lounge, in the Front Lobby, in the Main Dining Room, in the kitchen by the Main Dining Room entrance and in the kitchen at the back exit. Based on interview at the time of the observations, the	K0064	**K064 NFPA 101 Life Safety Code Standard** Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. The fire extinguishers have been replaced and the placard has been placed above the K-class portable fire extinguisher. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Fire extinguishers will be serviced and will be replaced as needed by	06/05/2012

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	Maintenance Supervisor acknowledged it has been more than six years since the most recent six year test was documented for fire extinguishers in the aforementioned locations. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 portable K-class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any staff or visitors in the vicinity of the kitchen.		an outside contractor. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Fire extinguishers are visually checked monthly by the Maintenance Supervisor and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, a placard was not conspicuously placed near the K- class portable fire extinguisher which states the fire protection system shall be activated prior to using the K-class portable fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the K-class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher. 3.1-19(b)			

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas of greater than 3000 cubic feet is enclosed within a one hour separation. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect residents, staff and visitors in the vicinity of the east oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, the east oxygen storage room contained four liquid oxygen canisters and the storage room door is not provided with a self closing device.	K0076	**K076 NFPA 101 Life Safety Code Standard** Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. An automatic door closure was added to the east oxygen storage room door. **What measures will be put into place or what systemic**	06/05/2012

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	Based on interview at the time of observation, the Maintenance Supervisor acknowledged the east oxygen storage room is not equipped with a self closing device on the door. 3.1-19(b)		**changes you will make to ensure that the deficient practice does not recur?** All hazardous areas will have automatic door closures. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Automatic closures are visually checked monthly and documented in the Preventative Maintenance Manual. The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure the 1 of 2 liquid oxygen transfilling areas was equipped with a door with a self closing or automatic closing device. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect residents, staff and visitors in the vicinity of the east oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Supervisor during a tour of	K0143	**K143 NFPA 101 Life Safety Code Standard** Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 **What corrective action(s) will be accomplished for those residents found to have been affected by the**	06/05/2012

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	the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, the east oxygen storage and transfilling room contained four liquid oxygen canisters and the transfilling room door is not provided with a self closing device on the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the east oxygen storage and transfilling room is not equipped with a self closing device on the door. 3.1-19(b)		**deficient practice?** There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. An automatic door closure was added to the east oxygen storage room. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An automatic door closure was added to the east oxygen storage room door. All hazardous areas will have automatic door closures. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Automatic closures are visually checked monthly and documented in the Preventative Maintenance Manual. The	

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			Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor during record review from 9:00 a.m. to 10:30 a.m. on 05/17/12, monthly load test documentation for the twelve month period from 05/16/11 through 04/16/12	K0144	**K144 NFPA 101 Life Safety Code Standard** Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. The transfer time will be logged weekly on the Emergency Generator – Weekly Exercise/Monthly Load Test Log. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The transfer time will be logged weekly on the Emergency Generator – Weekly	06/05/2012

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	lists the "Transfer Time" as how long the generator ran in minutes for each load test, but not how long it took to transfer power to the emergency generator. Based on interview at the time of record review, the Maintenance Supervisor acknowledged monthly load test documentation for "Transfer Time" does not record how long it took to transfer power to the emergency generator for each monthly load test. 3.1-19(b)		Exercise/Monthly Load Test Log. The Emergency Generator log will be reviewed by the Executive Director monthly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Executive Director will review the Preventative Maintenance Manual monthly. Findings will be presented to the Safety Committee for review.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could residents, staff and visitors in the vicinity of resident Room 246. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:30 a.m. to 12:35 p.m. on 05/17/12, an electric bed in resident Room 246 was plugged into a power strip and not directly into a wall outlet. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the electric bed in resident Room 246 was plugged into a power strip and not directly into a wall outlet. 3.1-19(b)	K0147	**K147 NFPA 101 Life Safety Code Standard** Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The power strip was immediately removed from Room 246. **How will you identify other residents having the potential to he affected by the same deficient practice and what corrective action will be taken?** All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff will be re-educated on power strip usage by the Maintenance Supervisor/designee by June 5,	06/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 01 B. WING	05/17/2012

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			2012. The Customer Care Representatives and nurses make rounds daily and will check for power strip usage. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The “Environmental Safety” CQI tool will be utilized weekly x 4 weeks then monthly ongoing. The results will be by the Executive Director and presented to the Quality Assurance Committee for review.	